STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS146S	A. BUILDING _____ B. WING _____	06/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH TRANSITIONAL REHABILITATION CENTE	2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey and complaint investigation conducted in your facility on June 2, 2009 through June 10, 2009, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00022009 was substantiated with deficiencies cited. (See Tags W473 and W112) Complaint #NV00021962 was substantiated with deficiencies cited. (See Tags W473 and W400) Complaint #NV00021805 was substantiated with deficiencies cited. (See Tags W473 and W112) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z112 SS=E	NAC 449.74439 Comprehensive Plan of Care 3. A comprehensive plan of care must be: a) Developed within 7 days after the completion of the initial comprehensive assessment required by NAC 449.74433 and periodically reviewed and revised after each subsequent assessment; and b) Prepared by an interdisciplinary team that includes the patient's attending physician, a registered nurse who is responsible for the care of the patient and such other members of the staff of the facility as are appropriate to provide services in accordance with the needs of the patient. To the extent practicable, the patient, his legal representative and members of his family must be allowed to participate in the development of the plan of care.	Z112		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z112	Continued From page 1 This Regulation is not met as evidenced by: Based on record reviews, documentation review, policy review, and interview, the facility failed to ensure the plan of care for 7 of 26 residents (#4, #9, #10, #13, #15, #22, #24) were updated. Findings include: Resident #4 Resident #4 was a 83 year-old male admitted to the facility on 4/8/09, with diagnoses including Old Cervical Fracture, History of Falls, Abnormality of Gait, Parkinson Disease, Mental Disorder Not Otherwise Specified, Depressive Disorder, and Esophageal Reflux. Record review: Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts with documentation of injury: 1). 5/2/09 at 1850 (6:50 PM) and suffered a skin tear to the left arm measuring 3 centimeters. 2). 5/9/09 at 1930 (7:30 PM) 3). 5/14/09 at 0640 (6:40 AM) 4). 5/26/09 at 1500 (3:00 PM) 5). 5/30/09 at 4:45 PM 6). 6/4/09 after lunch and suffered a laceration the left eye brow which required sutures. Review of the resident's Care Plan for Falls/Fall risk, dated 4/17/09, indicated the resident was a fall risk related to a history of falls, gait abnormality, Parkinson's disease, Dementia, Depression, old Cervical Spine Fracture, Debility and is on psychotropic medications. Further noted on the Care Plan, was a	Z112		

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Z112	Continued From page 2 documented fall on 5/2/09. On the second page of the Care Plan, it was noted that the care plan was reviewed and no changes to the plan will occur. There were no other documented updates to the resident's care plan and implemented changes following the 4 other falls between 5/9/09 and 5/30/09. Review of the facility's Post Fall Assessment, dated 5/2/09, indicated the resident was attempting to get up out of bed to stand and the apparent fall occurred. There was no other Post Fall Assessment documentation in the resident's record and available for review for the additional falls which occurred between 5/9/09 and 5/30/09. The Physician's Order, dated 5/26/09, indicated an order for a Bed Alarm for the resident's bed as a fall preventive measure. This order was in response to the resident's fall earlier during the day on 5/26/09. There was no documented evidence in the resident's record that this approach was on the resident's care plan or implemented. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident had documented falls on 5/2/09, 5/9/09, and 5/14/09. There was no documentation on the monthly log for the falls which occurred on 5/26/09 and 5/30/09. Resident #9 Resident #9 was 82 year-old female initially	Z112		

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Z112	Continued From page 3 admitted to the facility on 1/22/09, and readmitted on 1/29/09, with diagnoses including Anxiety Disorder, Chronic Back Pain, Anemia, Chest Pain, History of Coronary Artery Disease, Status Post Percutaneous Transluminal Coronary Angioplasty, Diabetes, and Hypothyroidism. Record review: Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts and injuries noted: 1). 3/10/09 during the day shift and required a right hand and middle finger X-ray. 1). 4/30/09 at 0340 (3:450 AM) and suffered deep tissue bruise around right eye. 2). 5/10/09 at 0645 (6:45 AM) and suffered a single broken rib. Review of the resident's Care Plan for Falls/Fall risk, dated 5/7/09, indicated the resident was a fall risk related to a history of falls, tries to be independent beyond capabilities, tries to ambulate by self, and on medication that may contribute to falls. Further noted on the Care Plan was a documented fall on 5/10/09. Additional documentation included resident diagnoses and current prescribed medications as of the care plan date. There was no evidence of the falls on 3/10/09 and on 4/30/09, noted on the resident's care plan. The fall on 5/10/09 was documented on the care plan, but no evidence of injury documented. There were two new interventions implemented following the fall on 5/10/09, which were frequent reminders and a low to floor bed. A recommendation for a psychiatric evaluation	Z112		

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Z112	Continued From page 4 during the interdisciplinary team meeting was not evident on the care plan as an approach. The Physician Orders, dated 5/28/09, revealed the order for a low to floor bed. Review of the physician orders at the time of the post fall assessment did not reveal evidence of orders for low bed and the psychiatric evaluation recommended during the Interdisciplinary team meeting. Review of the facility's Post Fall Assessment, dated 4/30/09, indicated the resident was attempting to ambulate to the bathroom and the apparent fall occurred. It was noted on the assessment that the bed was in a low position, however there was no physician order in the record and evidence of low bed in the resident's current care plan in place. Review of the Post Fall Assessment, dated 5/10/09, indicated the resident attempted to transfer from bed to her wheelchair when the accident occurred. It was indicated on the assessment that the bed was in a low position, however there was no evidence of a physician order or intervention documented in the current care plan prior to 5/10/09, and not until 5/28/09. Resident #10 Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder.	Z112		

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Z112	Continued From page 5 Documentation review: Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of injury: 1). 3/22/09, during the early morning 2). 3/24/09, during the evening and sent out for evaluation due to change of status. 3). 4/9/09, during the early morning 4). 4/10/09, during the early morning 5). 4/15/09, during the evening and sent out 2 days later for left arm weakness. Record review: Resident has had several admissions and discharges since the initial admission to the facility on 3/20/09. Below are the admission and discharge dates of the resident: 1). Admitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2). Readmitted on 3/31/09 and discharged on 4/17/09 due to left arm weakness 3). Readmitted on 4/20/09 Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the resident was a fall risk related to functional decline, unstable gait, and has diagnosis of Alzheimer Dementia. There was no documentation of evidence of the two previous falls on 3/22/09 and 3/24/09, which required the resident to be transferred out for evaluation. Review of the Care Plan for Falls/Fall Risk, dated 4/15/09, indicated the resident was a fall risk related to impulsive behaviors, tries to be independent beyond capabilities, unsteady gait, Alzheimer Dementia, and medications which could contribute to falls.	Z112		

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Z112	Continued From page 6 Review of the Care Plan for Falls/Fall Risk related to Alzheimer Disease, dated 5/4/09, indicated the resident was a fall risk due to the same indications noted in the above 4/15/09 plan. Again there was no updates to the resident's care plan with the five falls the resident has incurred and any new interventions to prevent the possibility of future falls. Further review of the two above aforementioned care plans had no evidence of five falls the resident incurred during the previous admission (3/22/09, 3/24/09) and the current admission (4/9/09, 4/10/09, 4/15/09). There was no indication of change with interventions that would possibly prevent further falls. An attempt to review the facility's Post Fall Assessments for each fall was unavailable. There was no evidence of the assessments following a fall. Interview: On 5/4/09 at 11:15 AM, Employee #12 indicated she had not completed the incident reports and post fall investigations as of this date. She indicated that there was no pattern to the resident's falls. She added that there were no reported injuries due to the falls. Employee #12 acknowledged during the interview that the assessments following falls assist the facility in care planning. Resident #13 Resident #13 was a 92 year-old female admitted to the facility on 1/7/09, and discharged on	Z112		

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Z112	Continued From page 7 2/21/09 to Nathan Adelson Hospice, with diagnoses including Hypertension Not Otherwise Specified, Hyperlipidemia, Status Post Right Hip Fracture/Repair, Depressive Disorder, Parkinson Disease, Dysphagia Not Otherwise Specified, Atrial Fibrillation, Anemia, Osteoporosis Not Otherwise Specified, and Anxiety State. Record review: Review of the resident's Nurse's Notes revealed the resident incurred two separate falls with no documented evidence of injury: 1). 1/16/09 during the evening shift 2). 2/12/09 during the evening shift while left unattended in the dining room. Review of the resident's Care Plan for Falls/Fall risk, dated 1/14/09, indicated the resident was at risk for falls due to history of fall with hip fracture, Parkinson, Depression, Anemia, Atrial fibrillation, and on medications that could contribute to falls. A Physician's Order, dated 1/16/09, revealed orders for X-rays of the resident's lateral hip, lumbar spine series, fall precautions, and place the resident in a low bed. Further review of the Care Plan revealed documentation of two falls on 1/16/09 and 2/12/09, and both were noted as no injury. There was no evidence of new interventions documented on the care plan. The second page of the care plan revealed documentation of "no change in plan of care" for 1/16/09 and 2/12/09, however, physician orders on 1/16/09 revealed a low bed order. Review of the Post Fall Assessment, dated 1/16/09, indicated the facility was unaware of the	Z112		

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Z112	Continued From page 8 resident's activity during the fall which occurred in the resident's room. It was indicated in the assessment that the resident was in a low bed prior to the fall. An order for low bed was written following the resident's fall. Review of the Post Fall Assessment, dated 2/12/09, indicated the resident was sitting in her wheelchair in the dining room when the fall occurred. The facility's Investigation Report, dated 2/12/09, indicated the resident was left unattended in the dining room when the fall occurred on 2/12/09. Resident #15 Resident #15 was a 55 year-old female admitted to the facility on 4/30/09, with diagnoses including Left Sided Weakness, Recurrent, Secondary to Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling. Record review: Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer. Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated	Z112		

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Z112	Continued From page 9 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. Following the resident's initial fall, It was noted on the plan that the facility had implemented siderails as an enabler and frequent reminders to ask for assistance. The intervention following the second fall was a X-ray due to the resident hitting her face on the floor. There was no evidence of an additional or different intervention which may prevent future falls. The second Care Plan, dated 5/7/09, noted the resident's third fall on 5/17/09. Interventions noted on the was to schedule an eye examination to get the resident new glasses. A second notation on the second page of the plan was on 5/20/09, which indicated no change to the plan of care. Resident #22 Resident #22 was a 69 year-old male admitted to the facility on 5/2/09, with diagnoses including Congestive Heart Failure Not Otherwise Specified, Insomnia, Acquired Hypothyroidism, Spasm of Muscle, Hypertension, Status Post Amputee Below Left Knee, Gangrene, Status Post Amputee Other Toe, and Diabetes Mellitis II Uncontrolled. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident incurred two falls soon after his admission on 5/2/09. Both falls (5/7/09, 5/8/09) occurred while the resident was in his room. The log did not contain any corrective actions corresponding to the two falls. Record review: Review of the initial Fall Risk Assessment, dated	Z112		

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Z112	Continued From page 10 5/2/09, rated the resident with a total score of "5" (10 and above is high risk). The resident has a incurred an amputation below the right knee and fourth toe to left foot with indications of additional amputations as noted in a 6/1/09 Doctor's Progress Note during a wound follow-up visit. Review of the two Care Plans for Risk for Falls, dated 5/7/09 and 5/11/09, indicated various facility approaches with no new interventions noted following the second fall. The Care Plan, dated 5/7/09, noted as a facility approach was to maintain the bed at the "lowest position". However, it was noted in a Physician Order on 5/28/09 to place the resident in a "low bed for safety" and "activity = W/C (wheelchair), and no wt. (weight) bearing to lf (left) leg." This order was 20 days following the second fall. Further review of the both plans did not indicate any new changes or updates following the second fall and after the new physician orders on 5/28/09. Resident #24 Resident #24 was an 88 year-old male admitted to the facility on 9/17/08, with diagnoses including Cellulitis Not Otherwise Specified, Depressive Disorder, Mental Disorder, Hypertension Not Otherwise Specified, Legal Blindness, rheumatoid Arthritis, restless Leg Syndrome, Long-Term Use antibiotics, Shortness of Breath, Esophageal Reflux, Hyperlipidemia Not Otherwise Specified, and Osteoporosis Not Otherwise Specified. Issue #1	Z112		

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Z112	Continued From page 11 Record review: Review of the facility's Nurse's Notes since admission on 9/17/08, revealed several falls the resident had incurred: 1). 10/19/08, during day shift 2). 3/10/09, during day shift 3). 3/19/09, during the evening shift 4). 3/21/09, during the day shift and hit head and complained of headache sent for head X-rays. 5). 4/27/09, during the evening shift and suffered skin tear. 6). 5/20/09, during the day shift Review of the resident's Care Plan, dated 12/24/08, noted falls the resident incurred on 10/19/08, 3/10/09, 3/21/09, and 4/27/09. The care plan did not note updates following the falls on 3/19/09 and 5/20/09. Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/20/09. The intervention indicated was "...frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear. Policy review: It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls.	Z112		

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Z112	Continued From page 12 It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional." It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #20, "The care plan will be updated, post fall, identifying the fall and goals and approaches to reduce the potential of future reoccurrence." It was further documented in the policy under procedure #14, "...the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying contributing factors to the event." And indicated in procedure #18, that the information obtained from the "Post Fall Assessment" review will be used to improve the resident's fall prevention plan. Based on record reviews, documentation review, policy review, and interview, the facility failed to ensure the plan of care for 7 of 26 residents (#4, #9, #10, #13, #15, #22, #24) were updated. Findings include: Resident #4 Resident #4 was a 83 year-old male admitted to the facility on 4/8/09, with diagnoses including Old Cervical Fracture, History of Falls, Abnormality of Gait, Parkinson Disease, Mental Disorder Not Otherwise Specified, Depressive Disorder, and Esophageal Reflux. Record review:	Z112		

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Z112	Continued From page 13 Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts with documentation of injury: 1). 5/2/09 at 1850 (6:50 PM) and suffered a skin tear to the left arm measuring 3 centimeters. 2). 5/9/09 at 1930 (7:30 PM) 3). 5/14/09 at 0640 (6:40 AM) 4). 5/26/09 at 1500 (3:00 PM) 5). 5/30/09 at 4:45 PM 6). 6/4/09 after lunch and suffered a laceration the left eye brow which required sutures. Review of the resident's Care Plan for Falls/Fall risk, dated 4/17/09, indicated the resident was a fall risk related to a history of falls, gait abnormality, Parkinson's disease, Dementia, Depression, old Cervical Spine Fracture, Debility and is on psychotropic medications. Further noted on the Care Plan, was a documented fall on 5/2/09. On the second page of the Care Plan, it was noted that the care plan was reviewed and no changes to the plan will occur. There were no other documented updates to the resident's care plan and implemented changes following the 4 other falls between 5/9/09 and 5/30/09. Review of the facility's Post Fall Assessment, dated 5/2/09, indicated the resident was attempting to get up out of bed to stand and the apparent fall occurred. There was no other Post Fall Assessment documentation in the resident's record and available for review for the additional falls which occurred between 5/9/09 and 5/30/09. The Physician's Order, dated 5/26/09, indicated	Z112		

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Z112	Continued From page 14 an order for a Bed Alarm for the resident's bed as a fall preventive measure. This order was in response to the resident's fall earlier during the day on 5/26/09. There was no documented evidence in the resident's record that this approach was on the resident's care plan or implemented. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident had documented falls on 5/2/09, 5/9/09, and 5/14/09. There was no documentation on the monthly log for the falls which occurred on 5/26/09 and 5/30/09. Resident #9 Resident #9 was 82 year-old female initially admitted to the facility on 1/22/09, and readmitted on 1/29/09, with diagnoses including Anxiety Disorder, Chronic Back Pain, Anemia, Chest Pain, History of Coronary Artery Disease, Status Post Percutaneous Transluminal Coronary Angioplasty, Diabetes, and Hypothyroidism. Record review: Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts and injuries noted: 1). 3/10/09 during the day shift and required a right hand and middle finger X-ray. 1). 4/30/09 at 0340 (3:450 AM) and suffered deep tissue bruise around right eye. 2). 5/10/09 at 0645 (6:45 AM) and suffered a single broken rib.	Z112		

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Z112	Continued From page 15 Review of the resident's Care Plan for Falls/Fall risk, dated 5/7/09, indicated the resident was a fall risk related to a history of falls, tries to be independent beyond capabilities, tries to ambulate by self, and on medication that may contribute to falls. Further noted on the Care Plan was a documented fall on 5/10/09. Additional documentation included resident diagnoses and current prescribed medications as of the care plan date. There was no evidence of the falls on 3/10/09 and on 4/30/09, noted on the resident's care plan. The fall on 5/10/09 was documented on the care plan, but no evidence of injury documented. There were two new interventions implemented following the fall on 5/10/09, which were frequent reminders and a low to floor bed. A recommendation for a psychiatric evaluation during the interdisciplinary team meeting was not evident on the care plan as an approach. The Physician Orders, dated 5/28/09, revealed the order for a low to floor bed. Review of the physician orders at the time of the post fall assessment did not reveal evidence of orders for low bed and the psychiatric evaluation recommended during the Interdisciplinary team meeting. Review of the facility's Post Fall Assessment, dated 4/30/09, indicated the resident was attempting to ambulate to the bathroom and the apparent fall occurred. It was noted on the assessment that the bed was in a low position, however there was no physician order in the record and evidence of low bed in the resident's current care plan in place.	Z112		

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Z112	Continued From page 16 Review of the Post Fall Assessment, dated 5/10/09, indicated the resident attempted to transfer from bed to her wheelchair when the accident occurred. It was indicated on the assessment that the bed was in a low position, however there was no evidence of a physician order or intervention documented in the current care plan prior to 5/10/09, and not until 5/28/09. Resident #10 Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder. Documentation review: Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of injury: 1). 3/22/09, during the early morning 2). 3/24/09, during the evening and sent out for evaluation due to change of status. 3). 4/9/09, during the early morning 4). 4/10/09, during the early morning 5). 4/15/09, during the evening and sent out 2 days later for left arm weakness. Record review: Resident has had several admissions and discharges since the initial admission to the facility on 3/20/09. Below are the admission and discharge dates of the resident: 1). Admitted on 3/20/09 and discharged on	Z112		

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Z112	Continued From page 17 3/25/09 due to a fall and change of condition 2). Readmitted on 3/31/09 and discharged on 4/17/09 due to left arm weakness 3). Readmitted on 4/20/09 Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the resident was a fall risk related to functional decline, unstable gait, and has diagnosis of Alzheimer Dementia. There was no documentation of evidence of the two previous falls on 3/22/09 and 3/24/09, which required the resident to be transferred out for evaluation. Review of the Care Plan for Falls/Fall Risk, dated 4/15/09, indicated the resident was a fall risk related to impulsive behaviors, tries to be independent beyond capabilities, unsteady gait, Alzheimer Dementia, and medications which could contribute to falls. Review of the Care Plan for Falls/Fall Risk related to Alzheimer Disease, dated 5/4/09, indicated the resident was a fall risk due to the same indications noted in the above 4/15/09 plan. Again there was no updates to the resident's care plan with the five falls the resident has incurred and any new interventions to prevent the possibility of future falls. Further review of the two above aforementioned care plans had no evidence of five falls the resident incurred during the previous admission (3/22/09, 3/24/09) and the current admission (4/9/09, 4/10/09, 4/15/09). There was no indication of change with interventions that would possibly prevent further falls. An attempt to review the facility's Post Fall Assessments for each fall was unavailable.	Z112		

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Z112	Continued From page 18 There was no evidence of the assessments following a fall. Interview: On 5/4/09 at 11:15 AM, Employee #12 indicated she had not completed the incident reports and post fall investigations as of this date. She indicated that there was no pattern to the resident's falls. She added that there were no reported injuries due to the falls. Employee #12 acknowledged during the interview that the assessments following falls assist the facility in care planning. Resident #13 Resident #13 was a 92 year-old female admitted to the facility on 1/7/09, and discharged on 2/21/09 to Nathan Adelson Hospice, with diagnoses including Hypertension Not Otherwise Specified, Hyperlipidemia, Status Post Right Hip Fracture/Repair, Depressive Disorder, Parkinson Disease, Dysphagia Not Otherwise Specified, Atrial Fibrillation, Anemia, Osteoporosis Not Otherwise Specified, and Anxiety State. Record review: Review of the resident's Nurse's Notes revealed the resident incurred two separate falls with no documented evidence of injury: 1). 1/16/09 during the evening shift 2). 2/12/09 during the evening shift while left unattended in the dining room. Review of the resident's Care Plan for Falls/Fall risk, dated 1/14/09, indicated the resident was at	Z112		

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Z112	Continued From page 19 risk for falls due to history of fall with hip fracture, Parkinson, Depression, Anemia, Atrial fibrillation, and on medications that could contribute to falls. A Physician's Order, dated 1/16/09, revealed orders for X-rays of the resident's lateral hip, lumbar spine series, fall precautions, and place the resident in a low bed. Further review of the Care Plan revealed documentation of two falls on 1/16/09 and 2/12/09, and both were noted as no injury. There was no evidence of new interventions documented on the care plan. The second page of the care plan revealed documentation of "no change in plan of care" for 1/16/09 and 2/12/09, however, physician orders on 1/16/09 revealed a low bed order. Review of the Post Fall Assessment, dated 1/16/09, indicated the facility was unaware of the resident's activity during the fall which occurred in the resident's room. It was indicated in the assessment that the resident was in a low bed prior to the fall. An order for low bed was written following the resident's fall. Review of the Post Fall Assessment, dated 2/12/09, indicated the resident was sitting in her wheelchair in the dining room when the fall occurred. The facility's Investigation Report, dated 2/12/09, indicated the resident was left unattended in the dining room when the fall occurred on 2/12/09. Resident #15 Resident #15 was a 55 year-old female admitted	Z112		

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Z112	Continued From page 20 to the facility on 4/30/09, with diagnoses including Left Sided Weakness, Recurrent, Secondary to Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling. Record review: Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer. Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. Following the resident's initial fall, It was noted on the plan that the facility had implemented siderails as an enabler and frequent reminders to ask for assistance. The intervention following the second fall was a X-ray due to the resident hitting her face on the floor. There was no evidence of an additional or different intervention which may prevent future falls. The second Care Plan, dated 5/7/09, noted the resident's third fall on 5/17/09. Interventions noted on the was to schedule an eye examination to get the resident new glasses. A second notation on the second page of the plan was on 5/20/09, which indicated no change to the plan of care.	Z112		

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Z112	Continued From page 21 Resident #22 Resident #22 was a 69 year-old male admitted to the facility on 5/2/09, with diagnoses including Congestive Heart Failure Not Otherwise Specified, Insomnia, Acquired Hypothyroidism, Spasm of Muscle, Hypertension, Status Post Amputee Below Left Knee, Gangrene, Status Post Amputee Other Toe, and Diabetes Mellitis II Uncontrolled. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident incurred two falls soon after his admission on 5/2/09. Both falls (5/7/09, 5/8/09) occurred while the resident was in his room. The log did not contain any corrective actions corresponding to the two falls. Record review: Review of the initial Fall Risk Assessment, dated 5/2/09, rated the resident with a total score of "5" (10 and above is high risk). The resident has a incurred an amputation below the right knee and fourth toe to left foot with indications of additional amputations as noted in a 6/1/09 Doctor's Progress Note during a wound follow-up visit. Review of the two Care Plans for Risk for Falls, dated 5/7/09 and 5/11/09, indicated various facility approaches with no new interventions noted following the second fall. The Care Plan, dated 5/7/09, noted as a facility approach was to maintain the bed at the "lowest position". However, it was noted in a Physician Order on 5/28/09 to place the resident in a "low bed for safety" and "activity = W/C (wheelchair), and no wt. (weight) bearing to lf (left) leg." This order was 20 days following the second fall.	Z112		

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Z112	Continued From page 22 Further review of the both plans did not indicate any new changes or updates following the second fall and after the new physician orders on 5/28/09. Resident #24 Resident #24 was an 88 year-old male admitted to the facility on 9/17/08, with diagnoses including Cellulitis Not Otherwise Specified, Depressive Disorder, Mental Disorder, Hypertension Not Otherwise Specified, Legal Blindness, rheumatoid Arthritis, restless Leg Syndrome, Long-Term Use antibiotics, Shortness of Breath, Esophageal Reflux, Hyperlipidemia Not Otherwise Specified, and Osteoporosis Not Otherwise Specified. Issue #1 Record review: Review of the facility's Nurse's Notes since admission on 9/17/08, revealed several falls the resident had incurred: 1). 10/19/08, during day shift 2). 3/10/09, during day shift 3). 3/19/09, during the evening shift 4). 3/21/09, during the day shift and hit head and complained of headache sent for head X-rays. 5). 4/27/09, during the evening shift and suffered skin tear. 6). 5/20/09, during the day shift Review of the resident's Care Plan, dated 12/24/08, noted falls the resident incurred on 10/19/08, 3/10/09, 3/21/09, and 4/27/09. The care plan did not note updates following the falls on	Z112		

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Z112	Continued From page 23 3/19/09 and 5/20/09. Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/20/09. The intervention indicated was "...frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear. Policy review: It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls. It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional." It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #20, "The care plan will be updated, post fall, identifying the fall and goals and approaches to reduce the potential of future reoccurrence." It was further documented in the policy under procedure #14, "...the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying contributing factors to the event." And indicated in	Z112		

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Z112	Continued From page 24 procedure #18, that the information obtained from the "Post Fall Assessment" review will be used to improve the resident's fall prevention plan. Severity 2 Scope 2	Z112		
Z265 SS=G	NAC 449.74477 Pressure Sores Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient: 1. Who is admitted to the facility without pressure sores does not develop pressure sores unless the development of pressure sores is unavoidable because of the medical condition of the patient; and This Regulation is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that 1 out of 26 residents (#16) was properly assessed and monitored to prevent the development of a sacral decubitus. Findings include: Resident #16 Resident #16 was an 86 year old female admitted to the facility on 3/16/09, with diagnoses including Hypothyroidism, Osteoporosis, Pulmonary Embolism/Infarction, Venous Thrombosis, Atrial Flutter, Dysphagia, and Urinary Track Infection. Record Review: The resident's initial History and Physical Examination, dictated 3/25/09, indicated the resident has a history of multiple diagnoses including a status post fall with 70% T12	Z265		

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Z265	Continued From page 25 compression fracture. Prior to her fall she was living with her husband at an assisted living facility. It was noted that the resident was pleasant and was in no acute distress and able to move all extremities. The History and Physical Examination further indicated, a plan for the resident to receive a rehabilitation consultation and the patient would be closely monitored. It was documented in the resident's Rehabilitation Consultation dated 3/19/09, that the resident was alert and oriented times three, but has impaired functional mobility, activities of daily living and self-care. It was further indicated in the consultation, a plan to continue physical therapy, occupational therapy to work on bed mobility, bed-to-chair transfers, self care, and activities of daily living. Initial Nursing Admission and Assessment, dated 3/16/09 at 1700 (5:00 PM), indicated the resident's skin was within normal limits (WNL) and there was no signs of decubitus ulcers or skin breakdown observed at the resident's coccyx and heels. An Initial Admission Skin Check, dated 3/17/09, indicated the resident had no wounds or open areas. It was indicated on the document that pressure reduction measures would be implemented and circled on the document were positioning pillows and a pressure reduction mattress. It was indicated in the resident's Minimum Data Set, admission assessment dated 3/23/09, that the resident's cognitive skills was noted as	Z265		

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Z265	Continued From page 26 modified independence (some difficulty in new situations). It was documented under the resident's physical functioning that the resident required extensive assistance with 2+ persons physical assist (3/3) for bed mobility. Also, indicated in the assessment the resident would require total dependence with 2+ persons physical assist (4/3) for transfers. Further documentation in the admission assessment indicated no presence of ulcers observed during the first 14 days and treatments implemented under skin treatment section were pressure relieving device for bed and other preventive or protective skin care. The Resident Assessment Protocol (RAP) triggered for a potential for pressure sores due to the resident's diminished bed mobility. There was no documented care plan prior to 4/1/09 (initial discovery of stage 3 pressure sore to the Coccyx) to address the potential for the development. Physician orders, dated 4/1/09, indicated an order to "Cleanse deep tissue injury to Coccyx with wound cleanser, pat dry & apply Duoderm." The order indicated that the site should be checked daily and dressing changed every 3rd day. There was no documentation in the care plan that would support the resident was turned and repositioned prior to the formation of the deep tissue injury of the Coccyx and following the change to the plan of care, which turn and reposition was marked as a new approach. It was indicated in the Wound Management Review document, dated 4/3/09, that the resident developed a deep tissue injury to Coccyx on 4/1/09 measuring (in centimeters) 4.0 x 3.0 intact,	Z265		

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Z265	Continued From page 27 purple and maroon coloration to skin. It was indicated that the current preventive measures in-place were a pressure reduction mattress, pillows for positioning and float heels. It also noted under staff recommendations, staff was to place the resident on a low air loss mattress and start prostat. Further documentation on the same Wound Management Review document, dated 4/17/09, revealed two new deep tissue injuries to the right and left posterior heels. It was indicated that the measure of the injury to the left heel was measured 1.5 X 1.5 X intact blister with wound bed was 100% maroon. The injury to the left posterior heel was noted to measured at 2.0 X 3.0 X intact blister with wound bed was 100% maroon. On 5/22/09, it was indicated during a wound management update that the resident's Coccyx wound was measured to be 7.0 X 2.4 X undermined which was 60% yellow, 20% red, and 20% purple. There was no documented evidence that revealed a physician order to turn and reposition the resident at a certain rate, even following the change in the resident's Plan of Care on 4/1/09, which noted a turn and repositioning approach to assist in the healing of the Coccyx wound. Observations: Between the dates of 6/2/09 thru 6/5/09 and 6/9/09 thru 6/10/09, observations indicated that the resident spent the majority of the morning and afternoons in bed in the same supine position. Pillows were observed on the left side of the resident between the resident and left-side bed	Z265		

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Z265	Continued From page 28 rail. There was no observations made that indicated the resident was turned and repositioned to one side and to another side so to relieve pressure off the resident's backside, specifically the Coccyx and Sacral area. Note: An observation was made on 6/9/09 during the day, in which the resident was transferred to a wheelchair and taken to the facility dining room. Additional observations of the resident being transferred to a wheelchair could not be confirmed during the above aforementioned dates of observation. Interview: On 6/9/09 at 7:45 AM, the facilities wound care physician acknowledged that the resident's pressure ulcer on the Coccyx occurred following admission to this facility. On 6/9/09 at 1:45 PM, Employee #10 indicated "...for the most part we shift the resident once an hour." The employee also indicated they now get the resident up each day for a couple of hours and when she first arrived, pillows were placed on each side of the resident. The employee was asked where they document that they have turned and repositioned the residents. She indicated that there wasn't a specific document to note when residents were turned and repositioned. On 6/9/09 at 2:00 PM, Resident #16 indicated that she should have received more therapy and couldn't remember being turned to one side to another so to relieve pressure off her bottom.	Z265		

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Z265	Continued From page 29 Severity 3 Scope 1	Z265		
Z400 SS=E	NAC 449.74523 Social Services 1. A facility for skilled nursing shall provide medically-related social services that are designed to assist the patients in the facility in enhancing or restoring their ability to function physically, socially and economically. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure social services assessed, documented and made recommendations for 3 of 26 residents who displayed inappropriate behaviors, had family issues and incorrect classifications. (Residents #5, #12, #24). Findings include: Resident #24 Resident #24 was an 87 year old male admitted to the facility on 9/17/09, with diagnoses to include Depressive Disorder, Hypertension, Legal Blindness, Rheumatoid Arthritis, Restless Legs Syndrome, Shortness of Breath, Osteoporosis and Esophageal Reflux. The resident was alert and oriented times three. Interview: On 6/3/09, the Administrator indicated the previous Social Worker was no longer employed and the new person had started employment two days before the start of the survey. Record Review The Nurse's Notes for Resident #24 documented on 2/10/09, 2/17/09, 2/19/09, 3/11/09 and 3/19/09	Z400		

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Z400	Continued From page 30 the resident was sexually abusive toward an unknown number of female residents (also see Tag W473). The notes revealed he was verbally abusive and sexually suggestive to female staff members. There was no documentation concerning Resident #24's behaviors in the Social Service Notes that concerned assessment or interventions. Resident #12 Resident #12 was a 75 year old male admitted to the facility on 5/8/09, with diagnoses to include Chronic Airway Obstruction, Chronic Ischemic Heart disease, Convulsions, Hypertension, Old Myocardial Infarction, Psychosis and Tobacco Use Disorder. The resident had a recent history of a Coronary Bypass Graft of five coronary vessels on April 20, 2009. The resident was discharged from the hospital to the facility on 5/8/09. Record Review: The Nurse's Notes dated 5/16/09, indicated the resident's son gave him a cigarette while on oxygen that resulted in the resident receiving burns to his face and arm (also see Tag F323). On 5/24/09, the resident was found smoking in the facility parking lot with oxygen in use, and the cigarette was given to him by his son. The Nurse's Notes documented on 5/16/09, 5/24/09 and 5/25/09, indicated the resident's son smelled of alcohol. The Nurse's Notes for Resident #12 dated	Z400		

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Z400	Continued From page 31 5/16/09, indicated the police department had to remove the inebriated son from the building after he became frustrated and verbally abusive with staff. There were several instances of family issues between Resident #12's former spouse and his son documented in the Nurse's Notes on 5/15/09, 5/16/09, 5/24/09 and 5/25/09, with concerns pertaining to the resident's safe discharge. There was no documented evidence in the Social Service Notes concerning interventions used to defuse the volatile situations that occurred during the resident's stay at the facility. Resident #5 Resident #5 was a 49 year old male admitted to the facility on 7/21/09, with diagnoses to include Anorexic Brain Damage, Sudden Cardiac Arrest, Acute Respiratory Failure, Seizures, Contractures, History of Renal Failure, Attention to Tracheostomy, Ventilator Dependent, and Hypertension. A Quarterly Social Service Note dated 4/29/09, indicated Resident #5 had no Advance Directive and was a full code. The resident had an Advance Directive from 2008 in his medical record that indicated he wished to be a, "Class II" (no CPR (cardiopulmonary resuscitation), no defibrillation). Severity 2 Scope 2	Z400		
Z473 SS=H	NAC 449.74539 Physical Environment	Z473		

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Z473	Continued From page 32 4. Ensure that each patient in the facility receives adequate supervision and devices to prevent accidents; This Regulation is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 8 of 26 residents received adequate supervision and assistive devices to prevent accidents and falls (Residents #12, #4, #9, #10, #13, #15, #22, #24). Findings include: Resident #12 Resident #12 was a 75 year old male admitted to the facility on 5/8/09, with diagnoses to include Chronic Airway Obstruction, Chronic Ischemic Heart disease, Convulsions, Hypertension, Old Myocardial Infarction, Psychosis and Tobacco Use Disorder. The resident had a recent history of a Coronary Bypass Graft of five coronary vessels on April 20, 2009. The resident was discharged from the hospital to the facility on 5/8/09. Record Review: The Nurse's Notes for Resident #12 documented the following: "5/16/09 1845 (6:45 PM) 1820 (6:20 PM) Family members son & (and) wife brought pt (patient-Resident #12) to the nursing station C (with) a burnt to face and head, suffered while smoking cigarettes." (no signature by nurse) "5/16/09 1830 (6:30 PM) Pt. (Resident #12) was outside smoking with family member The cigarette burns pt face and the canula melted in the pt nose. Pt son gave cigarette to the pt to	Z473		

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Z473	Continued From page 33 smoke. Pt son smell of alcohol. Pt complain of pain. Tylenol given 650 mg (milligrams) PO (by mouth) given. MD (medical doctor) notified. Pt son was calling supervise (?) stupid nurses Because we didn't send Pt to hospital right away. Unable to know the actual place when the Pt got burn. Pt son (name) brought Pt to the Nurse Station (300) O2 (oxygen) given by RN (registered nurse). Pt. around mouth looks black and R (right) arm looks red." "5/16/09 2000 (8:00 PM) This patient (Resident #12's name), was brought to the nurse by son (name) via wheelchair stating that pt. suffered burnt to face and hand while smoking cigarette outside. Pt's face was noted to be black mustache burnt. Pt was also complaining of burnt to right forearm. "...Pt son (name) (who smells like alcohol) was very irritated and was calling the nursing staff stupid idiots and retarded stated that he could have wheeled the father across the street..." "Pt was transferred to (name of hospital) ER (emergency room). "5/24/09 2300 (11:00 PM) seen patient (Resident #12) earlier with son (name) (same person as previously mentioned) outside facility parking lot, pt. in his wheelchair C O2 and smoking a cigarette..." Resident #12's Admission Summary to Sunrise Hospital dated 4/06/09, indicated "...Patient has been a heavy smoker..." Resident #12's Neurological Consultation conducted at Sunrise hospital dated 4/11/09, indicated "...He (Resident #12) proved to be a smoker who had last smoked prior to admission..."	Z473		

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Z473	Continued From page 34 Resident #12's Discharge Summary from Sunrise Hospital dated 5/8/09 indicated, "...Discharge Diagnoses: Long standing Heart Disease, Multiple Myocardial Infarctions (MI), Shortness of Breath (SOB) , Hypertension, history of Cerebrovascular Accident (CVA) in 2001 with residual left arm weakness, Bilateral Endarterectomy and has been a heavy smoker. A Facility Social Service Assessment Form for Resident #12 dated 5/13/09 indicated, "...MEDICAL HISTORY: Sunrise Hospital 4/6/09 to 5/8/09 CHF (Congestive Heart Failure), Heart Disease, Multiple MI, SOB, HTN (hypertension), H/O (history of) CVA 2001, DM (Diabetes Mellitus) H/O smoking, H/O heavy alcohol consumption, seizure D/O (disorder). MEMORY OF: Comments: Forgetful-mental abilities vary..." A Facility Activities Initial Assessment for Resident #12 dated 5/8/09, contained a notation, "Smoker" in the top right corner of the form. "...Diagnosis Hx (history of) heavy smoking, dementia..." The Minimum Data Set (MDS) for Resident #12 dated 5/13/09, indicated "...Memory a. Short term memory ok-seems/appears to recall after 5 minutes 1. Memory problem b. Long term memory ok-seems/appears to recall long past 1. memory problem..." The Smoking Safety Assessment for Resident #12 dated 5/9/09, indicated in the upper right hand corner, "non-smoker." The Assessment Area was crossed out and not filled in with information. A Resident Smoking Contract between Resident #12 and the facility dated 5/21/09, indicated the	Z473		

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Z473	Continued From page 35 following information: 1. The resident agreed to allow the facility to retain all smoking items. 2. The resident understood his smoking items would be returned to him for smoking privileges 3. The resident agreed not to share any of his smoking items with another resident. 4. The resident agreed not to light any smoking materials with another resident. 5. The resident agreed to return all smoking items to the charge nurse at the nurse's station. 6. The resident understood if he violated this contract to control his own smoking material he would give up the privilege to control his own smoking material. 7. The resident understood this agreement to ensure the safety of all the residents of the facility. Resident #12 signed the agreement dated 5/21/09. The facility Smoking Policy dated 3/05 and revised on 9/05, indicated the following: 1. Residents will be assessed for their ability to smoke safely on admission, quarterly and annually and with a significant change in condition where such change might impact prior assessment. 5. Residents assessed as not safe with smoking material will have supervised smoking privileges with staff. 6. Residents and families will be informed on the Smoking Policy and Smoking Contract at the time of admission and periodically reviewed at Resident Council, Care Plan and Family Council meetings.	Z473		

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Z473	Continued From page 36 There was no documentation that indicated Resident #12 had quit smoking or that any member of the resident's family indicated he had stopped smoking. The facility failed to properly assess Resident #12 to obtain whether or not he could smoke unsupervised or if he was capable of understanding the seriousness of smoking with oxygen in use. The Admission Packet for the facility contained no information for the family of the residents concerning smoking. Interviews: On 6/4/09 in the afternoon, the Administrator indicated Resident #12's son took him to the courtyard in the center of the facility. She indicated there were no witnesses to the incident when the resident was burned. The facility found out about the incident when the resident's son took him to the nurse's station and indicated the resident was burned with a cigarette. She indicated the son may have taken him to the other designated smoking area or the parking lot. On 6/4/09, Employee #12 indicated the Resident was an ex-smoker and had not smoked for six months. She indicated the resident asked the son for a cigarette and he gave it to him. She then said I am guessing I was not here. She indicated there was no way of knowing the resident's son was going to give him a cigarette. Employee #12 was asked it she knew the resident had a long history of heavy smoking and was he and the family informed on admission about the danger of oxygen use and smoking. She indicated, "It is on the door of the rooms, it's common sense." The Administrator and Employee #12 were asked why	Z473		

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Z473	Continued From page 37 Resident #12 and his son did not have supervised visits after the incident on 5/16/09. Employee #12, indicated after the resident was found smoking again in the parking lot on 5/24/09, the facility restricted the son's visitations from 10:00 AM to 2:00 PM. Employee #12 indicated Resident #12 had quit smoking for six months and was a non-smoker, there was no need to assess him for smoke safety. When asked, did the resident say he quit, she indicated it was somewhere in the notes. There was no documentation in Resident #12's medical record that he or his family indicated he stopped smoking. Resident #4 Resident #4 was a 83 year-old male admitted to the facility on 4/8/09, with diagnoses including Old Cervical Fracture, History of Falls, Abnormality of Gait, Parkinson Disease, Mental Disorder Not Otherwise Specified, Depressive Disorder, and Esophageal Reflux. Record review: The resident's initial History and Physical Examination indicated a history of falls, with evidence of an old cervical #1 fracture, Parkinson's disease, and gait abnormality. It was noted in the initial examination that the resident's plan was to initiate rehabilitation and monitor very closely. Prior to admission to this facility, the resident was seen at Nellis Air Base following a fall and complaints of headaches. Than the resident was	Z473		

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Z473	Continued From page 38 transferred to Sunrise Hospital and Medical Center for further work-up following a discovery of a possible cervical fracture which was an old healing fracture. The Fall Risk Assessment, dated 4/18/09, revealed that the resident's fall status was measured at a score of "18", placing the resident at high risk for falls due to a history of falls and his current clinical condition. It was noted on the assessment, that a score of "10" or above represents a high risk for the potential for falls. The Side Rail Assessment Tool, dated 4/15/09, indicated the resident required partial or total assistance to transfer, required staff cueing or assist with bed mobility with or without assistive device, continent of bowel/bladder with or without assist (consider plan to accommodate toileting needs), and restless in bed. It was further noted in the rail assessment that the interventions to be implemented were increased monitoring and the resident will have the side rails up at all times. Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts with injuries: 1). 5/2/09 at 1850 (6:50 PM) and suffered a skin tear of about 3 centimeters to left arm. 2). 5/9/09 at 1930 (7:30 PM) 3). 5/14/09 at 0640 (6:40 AM) 4). 5/26/09 at 1500 (3:00 PM) 5). 5/30/09 at 4:45 PM 6). 6/4/09 following lunch and suffered a laceration to the left eye brow requiring sutures. Review of the resident's Care Plan for Falls/Fall risk, dated 4/17/09, indicated the resident was a	Z473		

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Z473	Continued From page 39 fall risk related to a history of falls, gait abnormality, Parkinson's disease, Dementia, Depression, old Cervical Spine Fracture, Debility and is on psychotropic medications. Further noted on the Care Plan was a documented fall on 5/2/09 with no apparent injury. On the second page of the Care Plan, it was noted that the care plan was reviewed and no changes to the plan will occur. There were no other documented updates to the resident's care plan and implemented changes following the 4 other falls between 5/9/09 and 5/30/09. Review of the facility's Post Fall Assessment, dated 5/2/09, indicated the resident was attempting to get up out of bed to stand and the apparent fall occurred. There was no other Post Fall Assessment documentation in the resident's record and available for review for the additional four falls which occurred between 5/9/09 and 5/30/09. Additional post fall documentation required by facility's Fall Prevention policy was 72 hour neurological checks following an unwitnessed fall. The resident incurred five separate falls during the month of May 2009. Only two of the falls revealed actual neurological assessments noted on the facility's Neurological Assessment document. However, the checks were partially completed following the 5/2/09 and 5/9/09 falls (not fulfilling the 72 hour procedure). A Physician's Order , dated 5/26/09, indicated an order for a Bed Alarm for the resident's bed as a fall preventive measure. This order was in response to the resident's fall during the day on 5/26/09. There was no documented evidence to	Z473		

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Z473	Continued From page 40 support that this approach was documented on the resident's care plan or implemented to the resident's bed as a fall preventive device. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident had documented falls on 5/2/09, 5/9/09, and 5/14/09. There was no documentation on the monthly log for the falls which occurred on 5/26/09 and 5/30/09. Per facility Fall Prevention policy, the post fall assessments are utilized in determining and implementing approaches to assist in preventing future falls. Observations: Between 6/2/09 and 6/4/09, there was no observable signs that the resident had a bed alarm applied to his bed. The resident incurred two another fall on 6/4/09 during apparent self transfers while in his bedroom. Following the resident's fall on 6/4/09, stacked on the resident's bedside table were fall preventive devices. There was a bed pad alarm and a wheelchair alarm, as well as, the resident's bed was set at its lowest position. Interviews: Following announcement of the resident's fall on 6/4/09, following his return from the RNA (Restorative Nursing Aide) dining room, several interviews were conducted on 6/4/09 and 6/5/09. On 6/4/09 at 3:45 PM, Employee #17 was asked about the resident's fall following lunch. She	Z473		

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Z473	Continued From page 41 indicated the resident apparently transferred himself from his wheelchair to his bed and fell. She indicated the resident suffered a laceration to the left eyebrow. She added that the resident must have released the seat belt and fell during the transfer. She further indicated that the Restorative Aide brought the resident back from lunch and left him in the room or in the hallway. She mentioned that the resident likes to lay down in bed following lunch. She was asked if restorative staff would know to lay him down after lunch, which she indicated that they should know and could have laid the resident down in bed. On 6/4/09 at 4:05 PM, Employee #6 was asked about the various alarms that sat on the resident's bed side table. She indicated that those were new interventions to be used following the resident's fall after lunch. She also indicated the low bed was also a new order. She was asked about the Physician Order, dated 5/26/09, which was an order for a bed alarm. She indicated that she hadn't had time to follow-up on that order. She was asked about the wheelchair seat belt and if there was an order. She indicated that she wasn't sure there was an order for the self-release belt. On 6/5/09 at 9:15 AM, Employee #3 indicated that Employee #18 , who usually does not work Unit #3, transported the resident back to his unit after lunch yesterday (6/4/09). She mentioned that the Employee #18 wasn't aware that the	Z473		

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Z473	Continued From page 42 resident liked to go to bed after lunch. Employee # 3 further indicated that she was aware of the resident's preference to lay down after lunch. She acknowledged that she did not inform Employee #18 the resident's preference to lay down after lunch. She mentioned that her usual work area are Units #1 and #2. On 6/5/09 at 9:30 AM, Employee #18 indicated that she wheeled the resident back to Unit #300 and placed him outside of his room by the doorway. She indicated that she was not aware of the resident's preference to lay down after lunch. Employee #18 further indicated that she did not observe any alarms on the chair, just a self - release seat belt. Resident #9 Resident #9 was 82 year-old female initially admitted to the facility on 1/22/09, and readmitted on 1/29/09, with diagnoses including Anxiety Disorder, Chronic Back Pain, Anemia, Chest Pain, History of Coronary Artery Disease, Status Post Percutaneous Transluminal Coronary Angioplasty, Diabetes, and Hypothyroidism. Documentation: The facility's Monthly Incident/Accident Logs for March, April and May 2009 revealed the resident incurred 3 falls (3/10/09, 4/30/09, 5/10/09). The falls on 3/10/09 and 4/30/09 were determined to be isolated and no change to the resident's care plan occurred. Record review:	Z473		

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Z473	Continued From page 43 It was noted in the Rehabilitation Consultation, dated 2/5/09, that a plan was initiated for the resident to receive physical and occupational therapy to work with strengthening activities, range of motion exercises, bed mobility, bed to chair transfers, self care, and activities of daily living. It was also noted that the resident would be placed on fall precautionary measures. The RAP (Resident Assessment Protocol) Worksheet, dated 2/5/09, following the resident's initial MDS assessment revealed falls to be a problem area due to the resident's risk for falls secondary to her medications and unsteady gait. Documentation in the facility's Nurse's Notes indicated the resident incurred falls during the following dates and shifts: 1). 3/10/09 during day shift and suffered a bruise and required an X-ray of the right hand and middle finger. 2). 4/30/09 at 0340 (3:450 AM) and suffered deep tissue bruise around right eye. 3). 5/10/09 at 0645 (6:45 AM) and suffered broken ribs. Review of the X-ray results, dated 5/11/09, indicated an impression of at least one right inferolateral rib fracture. Review of the resident's Care Plan for Falls/Fall risk, dated 5/7/09, indicated the resident was a fall risk related to a history of falls, tries to be independent beyond capabilities, tries to ambulate by self, and on medication that may contribute to falls. Noted on the Care Plan was the documented fall on 5/10/09. Additional documentation included resident diagnoses and current prescribed	Z473		

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Z473	Continued From page 44 medications as of the care plan date. There was no evidence of the 3/10/09 fall and the fall on 4/30/09 documented on the plan. The fall on 5/10/09 was documented on the care plan, but no evidence of injury documented. There were two new interventions implemented following the fall on 5/10/09, which were frequent reminders and a low to floor bed. There was no indication of a psychiatric evaluation recommended during the post fall assessment. Further review of the physician orders in and around the time of the fall indicated no order for low to floor bed. The physician order which indicated a clarification order for a low to floor bed was dated on 5/28/09 and not at the time of the fall recommendations. Review of the facility's Post Fall Assessment, dated 4/30/09, indicated the resident was attempting to ambulate to the bathroom and the apparent fall occurred. It was noted on the assessment that the bed was in a low position, however there was no documentation in the record for this intervention and evidence of low bed in the resident's current care plan in place. The Facility Investigation Report, dated 4/30/09, indicated the result of the investigation was determined to be an isolated event. The management action taken to the incident was noted to be a Computerized Tomography (CT) Scan at Valley Hospital. It was noted on the report that no change to the plan of care. Review of the Post Fall Assessment, dated 5/10/09, indicated the resident attempted to transfer from bed to her wheelchair when the accident occurred. It was indicated on the	Z473		

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Z473	Continued From page 45 assessment that the bed was in a low position, however there was no evidence of a physician order or intervention documented in the current care plan prior to 5/10/09. The Facility Investigation Report, dated 5/10/09, indicated the result of the investigation was determined to be an impulsive act by the resident, didn't use the call light, and attempting tasks beyond her capabilities. The management action taken was to place the resident in a low to floor bed, obtain a psychiatric consultation related to her antidepressants, and change Restoril from as needed to routine. There was no documented evidence of a physician order for a psychiatric evaluation to review the use of the two antidepressants as of the 5/10/09. However, it was noted on the care plan that the resident's Zoloft was discontinued on 5/26/09. The resident's care plan, dated 5/7/09, noted a new order for Restoril 30 mg (milligrams) q (every) hs (night). The approach was conducted through a medication review by the pharmacy. Noted in a Social Services note, dated 5/28/09, was a conversation between the Social Worker and the resident. Several statements were noted in the note concerning the resident's latest fall on 5/10/09. The resident stated, "I had my light on for 20 minutes and no one came to help me. I had to go to the potty. I waited and waited and no one came." It was further noted by the resident, "I yelled to them and no one came to help me so I started to walk to the bathroom on my own and I fell down." Interview:	Z473		

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Z473	Continued From page 46 On 6/4/09 at 10:50 PM, Resident #9 acknowledged prior to the fall on 5/10/09, she used the call light, and than started yelling out and indicated that her roommate began to yell out to staff too. She indicated after awhile, no staff came and she attempted to get up to use the restroom than fell hitting the wheelchair. Next, the resident was asked about her first fall when she bruised her right eye. She indicated that she did use the call light to call staff. She mentioned that she is like an alarm clock and during the night she has to go to the bathroom. She was asked if staff check on her in the middle of the night. She indicated that they came in one night and haven't come in again. Resident #10 Resident #10 was a 67 year-old male initially admitted on 3/20/09, and readmitted on 4/20/09, with diagnoses including Attention to Gastrostomy, Chronic Obstructive Pulmonary Disease, Convulsions, Pneumonia, Dementia without Behavior Disturbances, Altered Mental Status, Anemia, and Seizure Disorder. Documentation review: Documentation in the facility's Monthly Incident/Accident Log revealed these documented falls with no evidence of documented injury: 1). 3/22/09, during the early morning 2). 3/24/09, during the evening and sent out for evaluation due to change of status. 3). 4/9/09, during the early morning 4). 4/10/09, during the early morning	Z473		

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Z473	Continued From page 47 5). 4/15/09, during the evening and sent out 2 days later for left arm weakness. Record review: Resident has had several admissions and discharges since the initial admission to the facility on 3/20/09. Below are the admission and discharge dates of the resident: 1). Admitted on 3/20/09 and discharged on 3/25/09 due to a fall and change of condition 2). Readmitted on 3/31/09 and discharged on 4/17/09 due to left arm weakness 3). Readmitted on 4/20/09 Review of the resident's Care Plan for physical mobility, impaired, dated 4/7/09, indicated the resident was a fall risk related to functional decline, unstable gait, and has diagnosis of Alzheimer Dementia. There was no documentation of evidence of the two previous falls on 3/22/09 and 3/24/09, which required the resident to be transferred out for evaluation. Review of the Care Plan for Falls/Fall Risk, dated 4/15/09, indicated the resident was a fall risk related to impulsive behaviors, tries to be independent beyond capabilities, unsteady gait, Alzheimer Dementia, and medications which could contribute to falls. Review of the Care Plan for Falls/Fall Risk related to Alzheimer Disease, dated 5/4/09, indicated the resident was a fall risk due to the same indications noted in the above 4/15/09 plan. Again there was no updates to the resident's care plan with the five falls the resident has incurred and any new interventions to prevent the possibility of future falls.	Z473		

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Z473	Continued From page 48 Further review of the two above aforementioned care plans had no evidence of five falls the resident incurred during the previous admission (3/22/09, 3/24/09) and the current admission (4/9/09, 4/10/09, 4/15/09). There was no indication of change with interventions that would possibly prevent further falls. An attempt to review the facility's Post Fall Assessments for each fall was unavailable. There was no evidence of the assessments following a fall. Interview: On 5/4/09 at 11:15 AM, Employee #12 indicated she had not completed the incident reports and post fall investigations as of this date. She indicated that there was no pattern to the resident's falls. She added that there were no reported injuries due to the falls. Employee #12 further indicated during the interview that the post fall assessments assist the facility in determining new approaches during the care planning process to prevent future falls or accidents. Resident #13 Resident #13 was a 92 year-old female admitted to the facility on 1/7/09, and discharged on 2/21/09 to Nathan Adelson Hospice, with diagnoses including Hypertension Not Otherwise Specified, Hyperlipidemia, Status Post Right Hip Fracture/Repair, Depressive Disorder, Parkinson Disease, Dysphagia Not Otherwise Specified, Atrial Fibrillation, Anemia, Osteoporosis Not Otherwise Specified, and Anxiety State.	Z473		

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Z473	Continued From page 49 Record review: Review of the resident's Nurse's Notes revealed the resident incurred two separate falls with no documented evidence of injury: 1). 1/16/09 during the evening shift 2). 2/12/09 during the evening shift while left unattended in the dining room. Review of the resident's Care Plan for Falls/Fall risk, dated 1/14/09, indicated the resident was at risk for falls due to history of fall with hip fracture, Parkinson, Depression, Anemia, Atrial fibrillation, and on medications that could contribute to falls. A Physician's Order, dated 1/16/09, revealed orders for X-rays of the resident's lateral hip, lumbar spine series, fall precautions, and place the resident in a low bed. Further review of the Care Plan revealed documentation of two falls on 1/16/09 and 2/12/09, and both were noted as no injury. There was no evidence of new interventions documented on the care plan. The second page of the care plan revealed documentation of "no change in plan of care" for 1/16/09 and 2/12/09, however physician orders on 1/16/09 revealed a low bed order. Review of the Post Fall Assessment, dated 1/16/09, indicated the facility was unaware of the resident's activity during the fall which occurred in the resident's room. It was indicated in the assessment that the resident was in a low bed prior to the fall. An order for low bed was written following the resident's fall. Review of the Post Fall Assessment, dated	Z473		

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Z473	Continued From page 50 2/12/09, indicated the resident was sitting in her wheelchair in the dining room when the fall occurred. The facility's Investigation Report, dated 2/12/09, indicated the resident was left unattended in the dining room when the fall occurred on 2/12/09. Resident #15 Resident #15 was a 55 year-old female admitted to the facility on 4/30/09, with diagnoses including Left Sided Weakness, Recurrent, Secondary to Recurrent Cerebrovascular Accident, History of Acute renal Failure and Chronic Kidney Disease on Hemodialysis, Status Post Aspiration Pneumonia, Fungal Dermatitis, History of Diabetes, Hypertension, and Left Upper Extremity Swelling. Record review: Review of the three Post Fall Assessments contained in the record indicated the resident incurred three falls during the month of May 2009 (5/4/09, 5/11/09,5/17/09). All three falls occurred in the resident's bedroom while attempting to transfer. Review of the two Care Plans for Risk of Falls, dated 5/4/09 and 5/7/09, noted all three falls that the resident had incurred. The Care Plan dated 5/4/09, noted the first two falls on 5/4/09 and 5/11/09. Following the resident's initial fall, It was noted on the plan that the facility had implemented siderails as an enabler and frequent reminders to ask for assistance. The intervention following the second fall was a X-ray due to the resident hitting her face on the floor. There was	Z473		

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Z473	Continued From page 51 no evidence of an additional or different interventions or approaches which may prevent future falls. The second Care Plan, dated 5/7/09, noted the resident's third fall on 5/17/09. Interventions noted on the was to schedule an eye examination to get the resident new glasses. A second notation on the second page of the plan was on 5/20/09, which indicated no change to the plan of care. Resident #22 Resident #22 was a 69 year-old male admitted to the facility on 5/2/09, with diagnoses including Congestive Heart Failure Not Otherwise Specified, Insomnia, Acquired Hypothyroidism, Spasm of Muscle, Hypertension, Status Post Amputee Below Left Knee, Gangrene, Status Post Amputee Other Toe, and Diabetes Mellitis II Uncontrolled. Documentation review: Review of the facility's Monthly Incident/Accident Log for May 2009, indicated the resident incurred two falls soon after his admission on 5/2/09. Both falls (5/7/09, 5/8/09) occurred while the resident was in his room. The log did not contain any corrective actions corresponding to the two falls. Record review: Review of the initial Fall Risk Assessment, dated 5/2/09, rated the resident with a total score of "5" (10 and above is high risk). The resident has a incurred an amputation below the right knee and fourth toe to left foot with indications of additional	Z473		

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Z473	Continued From page 52 amputations as noted in a 6/1/09 Doctor's Progress Note during a wound follow-up visit. Review of the two Care Plans for Risk for Falls, dated 5/7/09 and 5/11/09, indicated various facility approaches with no new interventions noted following the second fall. The Care Plan, dated 5/7/09, noted as a facility approach was to maintain the bed at the "lowest position". However, it was noted in a Physician Order on 5/28/09 to place the resident in a "low bed for safety" and "activity = W/C (wheelchair), and no wt. (weight) bearing to lf (left) leg." This order was 20 days following the second fall. Further review of the both plans did not indicate any new changes or updates following the second fall and after the new physician orders on 5/28/09. Resident #24 Resident #24 was an 88 year-old male admitted to the facility on 9/17/08, with diagnoses including Cellulitis Not Otherwise Specified, Depressive Disorder, Mental Disorder, Hypertension Not Otherwise Specified, Legal Blindness, rheumatoid Arthritis, restless Leg Syndrome, Long-Term Use antibiotics, Shortness of Breath, Esophageal Reflux, Hyperlipidemia Not Otherwise Specified, and Osteoporosis Not Otherwise Specified. Record review: Review of the facility's Nurse's Notes since admission on 9/17/08, revealed several falls the resident had incurred and some injuries:	Z473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS146S	A. BUILDING _____ B. WING _____	06/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z473	Continued From page 53 1). 10/19/08, during day shift 2). 3/10/09, during day shift 3). 3/19/09, during the evening shift 4). 3/21/09, during the day shift and hit head and complained of headache sent for head X-rays. 5). 4/27/09, during the evening shift and suffered skin tear. 6). 5/20/09, during the day shift Review of the resident's Care Plan, dated 12/24/08, noted falls the resident incurred on 10/19/08, 3/10/09, 3/21/09, and 4/27/09. The care plan did not note updates following the falls on 3/19/09 and 5/20/09. Further review of the plan revealed on the second page indicated no new changes or updates occurred following the early falls until seven days after the resident's fall on 4/20/09. The intervention indicated was "...frequent verbal reminders to ask for assistance." Also, noted on the second page of the plan was treatment to the resident's skin tear. Policy review: It was indicated in the facility's Fall Prevention that the facility would assess resident for the risk of falls and to follow-up and evaluate falls in order to assess the resident's condition. It further indicated that the assessment of the falls would identify the reason for the fall and would assist in the preparation of a plan of care which could reduce the potential for future falls. It was indicated under the purpose subsection of the policy, that all residents would receive a "prompt assessment and treatment immediately following any fall or injury by the appropriate health professional."	Z473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z473	Continued From page 54 It was documented under the procedure subsection of the facility's Fall Prevention, that under procedure #20, "The care plan will be updated, post fall, identifying the fall and goals and approaches to reduce the potential of future reoccurrence." It was further documented in the policy under procedure #14, "...the nursing "Post Fall Assessment" will be completed by the charge nurse within 24 hours to assist in identifying contributing factors to the event." And indicated in procedure #18, that the information obtained from the "Post Fall Assessment" review will be used to improve the resident's fall prevention plan. Severity 3 Scope 2	Z473		